STATE OF MAINE
BOARD OF ALCOHOL AND DRUG COUNSELORS

Application for the Advanced Alcohol & Drug Counselor Examination Approval (AADC)
(Required for the Licensed Alcohol and Drug Counselor) (LADC)

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing) 35 State House Station, Augusta, ME 04333
(Physical Location) 76 Northern Ave. Gardiner, ME 04345

Office Telephone: (207) 624-8674
Office Facsimile: (207) 624-8637
TTY USERS CALL MAINE RELAY 711
Internet: www.maine.gov/professionallicensing

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35 STATE HOUSE STATION, AUGUSTA ME 04333 WEBSITE: WWW.MAINE.GOV/PROFESSIONALLICENSING

APPLICATION INSTRUCTIONS

REQUEST FOR EXAMINATION APPROVAL

Helping Tool: This is a checklist to help you identify the documents for submission with your application. (This is an abbreviated checklist and does not replace the requirements outlined in the Alcohol and Drug Counseling Laws and Rules. Please review them carefully for more detailed and clarifying information.) You must submit a complete application and all required documents and information.

Fax submissions of applications and supporting documentation will not be accepted.

- **Completed Application**
  Complete and sign the application and submit with the appropriate fees and documentation.
- **Proof of age**
  A copy of your official birth certificate or other official legal document is acceptable.
- **Proof of Clinically Supervised Work Experience**
  Submit completed verification of clinically supervised work experience form.
- **Proof of Education**
  Submit documentation of the highest education you have obtained.

Processing Time

✓ Your application has greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. Once reviewed, you will receive written correspondence by email.

✓ Please refrain from calling our office to "check" on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
Mailing Address: 35 State House Station, Augusta, Maine 04333 - **Courier/Delivery address**: 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** Gardiner Annex, 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** Due to the Covid-19 pandemic, and until further notice, the Gardiner Annex that houses the Office of Professional and Occupational Regulation and other agencies is closed to the public. OPOR staff members work remotely from 8 am to 5 pm to review and process license applications. We advise you to mail paper applications to 35 State House Station, Augusta, ME 04333.
- **Can I come to Gardiner to drop off my application?** No, the Gardiner Annex is closed to the public until further notice due to the Covid-19 pandemic. Please mail your paper application to our mailing address—35 State House Station, Augusta, ME 04333.
- **Can I come to Gardiner to pick up my license?** No. Your license will be emailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.

PLEASE ALSO SEE THE WEBSITE FOR THE OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION FOR ADDITIONAL QUESTIONS: https://www.maine.gov/pfr/professionallicensing/licensee_faq.html

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the discipline question
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) *or* credit card information (plus signature)
- Include any required transcripts or exam results
- **Make a copy of your application to keep for your records**
- DO NOT SEND CASH.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE APPLICATION

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME *FIRST* *MIDDLE INITIAL* *LAST*			
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH *mm / dd / yyyy*		SOCIAL SECURITY NUMBER - -	
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL	

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE **DATE**

State Board of Alcohol and Drug Counselors

Request for Advanced Alcohol & Drug Counselor (AADC)

Office Use Only:
LC 1447 - $25.00

LICENSE TYPE: (CHECK BOX)

☐ **LADC** - LICENSED ALCOHOL AND DRUG COUNSELOR (LC)

(AADC EXAMINATION)

Required Fees: $25.00 (Non-Refundable)

Rev. 7/2021

Check #_____
Amount:_____
Cash #_____
Lic. #_____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" – if you wish to pay by Mastercard, Visa, Discover or American Express fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*

I authorize the Department of Professional and Financial Regulation, Office of Professional & Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS the following amount: $_____

☐ **I understand that fees are non-refundable**

Card number: *XXXX-XXXX-XXXX-XXXX* Expiration Date *mm / yyyy*

SIGNATURE **DATE**

SECTION 1: EDUCATION

Please check one:		
□ High School Diploma or GED	□ MHRT/C	
□ Associate's Degree	□ Substance Abuse Rehabilitation Certificate	
□ Bachelor's Degree	□ Master's Degree	□ Other describe: _____

Name of Educational Provider	Date of Graduation

Contact Address: Street or P.O. Box		
City	State	Zip Code

A copy of your Official transcript demonstrating your education must be submitted with your application

SECTION 2: EXAMINATION

Have you ever taken an ICRC examination?

If yes, list the jurisdiction(s) where you took the examination, type of examination, date of examination and score:

Location Site City, State	Examination Type	Date	Score

□ Yes
□ No

SECTION 3: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), defaced, or compromised will not be accepted and will be cancelled. This includes, but is not limited to, unanswered questions, lack of appropriate signature, illegible information, missing required supporting documents, and/or missing or wrong fee.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Alcohol & Drug Counselors will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Printed Name of Applicant	Title
Signature of Applicant	Date

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
STATE BOARD OF ALCOHOL AND DRUG COUNSELORS
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8674 – FAX:(207)624-8637

VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE

Name of Applicant:		
Address:		
City:	State:	Zip:
Applicant's Job Title:		Telephone #:

The following section is to be completed by employer or supervisor only

Name of Agency: _____

Address: _____

Clinically supervised work experience must be <u>obtained while licensed</u>. Please include the applicant's valid license type and number.

Date of employment/ Dates worked to obtain hours (mm/yyyy)	Applicant's License Type	Applicant's License Number	Work area of practice that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	

VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE (Continued)

Date of employment/ Dates worked to obtain hours (mm/yyyy)	Applicant's License Type	Applicant's License Number	Type of Work Experience that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
TOTAL NUMBER OF HOURS OF CLINICALLY SUPERVISED ALCOHOL AND DRUG COUNSELING WORK EXPERIENCE:				

Did you personally supervise the above named applicant during the timeframe indicated on this form? ☐ **Yes** ☐ **No**

If no, describe your relationship with the applicant and include name and license number of Certified Clinical Supervisor: _____

_____

I, the _____ of the above named applicant, certify that the information provided on this form is verifiable, factual and accurate.
(i.e. supervisor, human resources, etc)

Print Name: _____ License #: _____

Title: _____

Signature: _____ Date: _____

TO SUPERVISOR COMPLETING THIS FORM: Return this completed form directly to the applicant; not the Board.

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35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
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Americans with Disabilities Act (ADA)
Request for Reasonable Accommodation

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your written permission.
Accommodations Requested for the Advanced Alcohol & Drug Counselor (AADC) Examination.

Name: _____

Address: _____

Telephone #: _____ Social Security #: _____

Disability: _____

Please check all that apply

- ☐ **Accessible Testing Site**
- ☐ **Separate Testing Site**
- ☐ **Braille**
- ☐ **Large Print**
- ☐ **Tape**
- ☐ **Reader as Accommodation for Visual Impairment**
- ☐ **Scribe/ Amanuensis as Accommodation for Visual or Motor Impairment**
- ☐ **Reader as Accommodation for Learning Disability**
- ☐ **Scribe/ Amanuensis as Accommodation for Learning Disability**
- ☐ **Sign Language Interpreter**
- ☐ **Extended Time**
  - ☐ **Time-and-a-half**
  - ☐ **Double time**
  - ☐ **More than double time (specify): _____**
- ☐ **Use of computer or Other Adaptive Equipment (specify): _____**
- ☐ **Other:**

_____

_____

Signed and dated: _____

DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in
(Test applicant) (Date)

my capacity as a _____.
(Professional Title)

This applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, providing the following should accommodate him/her:
(check all that apply):

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
  ☐ Time-and-a-half
  ☐ Double time
  ☐ More than double time (specify): _____
☐ Use of Computer or other adaptive equipment (specify): _____
☐ Other:

_____

_____

Signed: _____ Title: _____

Date: _____ License # (if applicable): _____